STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

INITIAL APPLICATION PACKET
FOR COMPREHENSIVE CARE & EXTENDED CARE FACILITIES

An initial application packet, consisting of the items noted below, must be submitted to the Long-Term Care unit of the Office of Health Care Quality for review and approval. The application packet must include all required documentation, signatures and notary on the appropriate forms. A licensure fee based on the LONG-TERM CARE PROVIDER APPLICATION must be included with the initial application packet.

Please make checks payable to: "Maryland Department of Health and Mental Hygiene". If you need additional information or questions please call 410-402-8201.

A. Application for Licensure
B. Principal Physician Agreement & Relief Physician Agreement
C. Director of Nursing Agreement
D. Facility Ownership (Medicaid Application. Must be notarized) - ***If the applicant has already completed an application for Medicaid, and all the information requested in the enclosed packet is included, a copy of the completed notarized application may be submitted in lieu of the application in this packet.***
E. State Affidavit
F. Workers' Compensation Law Questionnaire
G. Certificate of Compliance, as applicable
H. Evidence of Financial Ability to Operate (Alternative Formats permitted)
I. Adverse Legal Actions/Convictions
J. Chain Home Office Information
K. Form CMS - 671 Long Term Care Facility Application for Medicare and Medicaid
L. Civil Rights Information Request Questionnaire Form No. OMB 0990-0243 (CMS form)
M. CMS 690 – Assurance of Compliance for Civil Rights Act -Two originals required. ***(For Medicare facilities)***
N. CMS 1561 – Health Insurance Benefits Form -Two originals required. ***(For Medicare Facilities*****)**
O. Copy of Policies and Procedures
P. Transfer Agreement with a Local Hospital
Q. Notice of completion of CHOW – A letter documenting the date the transaction occurred.
R. Compliance History Form
S. Certificate of Need (or exemption) from the Maryland Health Care Commission (MHCC). You will need to apply to the MHCC for a pre-certification review. We require a copy of their review and approval or exemption.

SECTION A - LONG TERM CARE PROVIDER APPLICATION

APPLICANT INFORMATION E-mail_____ Fax_____

Name of Facility_____ Telephone No_____

Location_____
(Street)

_____
(City) (County) (Zip)

TYPE OF BUSINESS ORGANIZATION
□ Individual □ Partnership □ Corporation □ Association □ Other:_____

TYPE OF CONTROL □ Proprietary □ Voluntary Non-Profit: □ Church □ Other (Specify)_____
□ Government Unit: □ State □ City □ County

LEASING ARRANGEMENT (If an entity operates the business under a lease, the following section shall be completed):
Lessee Name(s) and Address(es)_____
Lessor Name(s) and Address(es)_____
Expiration Date of Lease _____

Applications on behalf of a corporation, association, government unit or agency shall be made by two officers of the corporation, association or governmental unit or agency and names and addresses of their board members shall be submitted.

Administrator_____ Administrator License No:_____

LONG TERM CARE FACILITY TYPE

□ Nursing Home Comprehensive Care Facility
□ Hospital Extended Care Facility
Number of Beds_____
□ Room & Bed breakdown attached

□ Does facility operate a special care unit?
□ YES: Type_____
Number of Beds_____
□ NO

The 2-year license fee of $_____ (see fee rates below) is to be attached to the application. **(Fee is not refundable).** Make check or money order payable to "Maryland State Department of Health and Mental Hygiene"
Fee: 1 – 50 beds, $3,000 51-99 beds, $5,000 100+beds, $7,000 Transitional care unit, $600

I/We_____
(Please Print)
certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under by the Secretary of Health and Mental Hygiene.

1. Signature of Applicant_____ **Title**_____

2. Signature of Applicant_____ **Title**_____

Sworn and subscribed to before me this _____day of _____, _____ a Notary Public for the State of Maryland.

My Commission expires _____ _____
Notary Public

SEND COMPLETED APPLICATION TO:

Office of Health Care Quality
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville MD 21228

FOR OFFICE USE ONLY

□ **Initial** **Date:**_____ **Amt PD:** _____
□**Renewal** **Ck#:** _____ **Coord Name:** _____
□ **Change of Ownership** **Registration #:**_____ **License#:**_____

DHMH 125A – Revised 3/16/2010

SECTION B – LONG TERM CARE PROVIDER APPLICATION

PRINCIPAL PHYSICIAN AGREEMENT

Name of Facility: _____ License #:_____

NOTE: ***The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Principal Physician and a qualified relief to cover periods when his or her services are not available.***

As Principal Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*

2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*

3. *I will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I will participate in the development of patient care policies, at lease annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*

6. *I will be responsible for the surveillance of employee's health program.*

_____ _____

Principal Physician (signature) *Date*

Principal Physician Information (please type of print)

Name:_____

(First) (Middle) (Last)

Medical License Number: _____

Address:_____

City:_____ State:_____ Zip code:_____

Telephone Number(s):_____

SECTION B – LONG TERM CARE PROVIDER APPLICATION

RELIEF PHYSICIAN AGREEMENT

Name of Facility: _____ License #:_____

NOTE: ***The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as a Principal Physician and a qualified relief to cover periods when his or her services are not available.***

As Relief Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*

2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*

3. *I will provide medical direction and coordination of the facility's medical care.*

4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*

5. *I will participate in the development of patient care policies, at lease annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*

6. *I will be responsible for the surveillance of employee's health program.*

_____ _____

Relief Physician (signature) *Date*

Relief Physician Information (please type of print)

Name:_____

(First) (Middle) (Last)

Medical License Number: _____

Address:_____

City:_____ State:_____ Zip code:_____

Telephone Number(s):_____

SECTION C – LONG TERM CARE PROVIDER APPLICATION

DIRECTOR OF NURSING AGREEMENT

Name of Facility: _____ License #:_____

****

This is to certify that I, _____ am a
Name

A. **Registered Nurse,** registry number _____

B. **Licensed Practical Nurse,** Board of Nursing registry number_____

and employed as **Director Of Nursing** for the above-name facility and carry the supervisory responsibilities of this position as described in State Regulations 10.07.02 par. 12 C & G.

My agreement with the **Administrator** requires that I be on duty _____**days** per week and work a minimum of 40 hours per week.

_____ _____
Director of Nursing (signature) *Date*

****

The above statement is correct and in accordance with the conditions under which

_____ is employed by this facility.
(*Director of Nursing)*

_____ _____
Facility Administrator (signature) *Date of Agreement*

****

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION INSTRUCTIONS

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at 410-767-5340

.

NOTE:
PLEASE ATTACH A COPY OF ALL REQUESTED DOCUMENTS

1) APPLICATION TYPE
Check the appropriate box. If the request is to change existing data, then you must also include your Medicaid Provider Number. If you have already rendered service please indicate a Requested Enrollment Begin Date. The Provider Enrollment Unit will backdate your application (3) months prior to its receipt date. The enrollment begin date for an approved application is based on the date the application is received in our office.

2) PROVIDER INFORMATION
If you have a business, such as a pharmacy or medical supply, or a professional group enter the company name or the corporate group name. All physicians and other individual practitioners should enter last name, first name, middle initial and professional title.

Enter the address telephone and fax number of your primary practice location, contact person name and their telephone number and the practice e-mail or website address. Enter a **"Y"** for Yes or a "**N"** for No if your office is handicap accessible.

Enter the appropriate two-digit code for the county of your business practice location address. A listing of the county codes is provided for your reference at the end of these instructions.

Enter the Federal Employer ID Number and/or Social Security Number of the individual, group or business to whom the Medicaid reimbursements will be made.

3) LICENSE/PERMIT INFORMATION
Enter your medical license number, beginning effective date and expiration date for your practice location in which you service Maryland Medicaid recipients. If out of state, attach a copy of the current license certificate. Enter your NABP number if applicable.

Enter your Drug Enforcement Agency number and attach a copy of your DEA certificate. If you do not have a DEA number, this box should be left blank.

Enter your pharmacy permit number, if applicable.

Medical laboratory providers, practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** the following:

Enter Clinical Laboratory Improvement Amendment (CLIA)#
Attach a copy of the CLIA certificate
Enter Maryland Laboratory Permit or Letter of Permit Exception #
Attach a copy of Maryland Laboratory Permit or Letter of Permit Exception #

Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland.

Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.

4) PRACTICE INFORMATION
Enter the appropriate two-digit code for your type of practice. If this does not apply, leave blank. For your reference, a listing of the practice codes is provided at the end of these instructions.
If you are applying as an HMO, enter FR to indicate the type of contract as Full Risk with Abortion or SL to indicate t he type of contract as Stop Loss without Abortion. In addition, please complete and sign the enclosed form DHMH 4126-G located at the end of the application. Otherwise, leave this blank.

5) SPECIALTY INFORMATION
Enter a "P" to designate the primary specialty. If multiple specialty codes are entered, then you must designate one specialty as the primary specialty.

Physicians, Dentists and Pharmacies MUST enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Enter OTH is you have another specialty not listed. PLEASE SPECIFY.

Enter the date you were certified for your specialty in MMDDYY format.

Enter the number, up to six digits, that was provided to you when you were certified for the associated specialty.

6) SPECIALTY VERIFICATION
Please check the applicable statement and attach the required documentation.

7) GROUP MEMBERSHIP INFORMATION
If you are a MEMBER OF A GROUP PRACTICE, please enter the name, Maryland Medicaid provider number and membership effective date for the group. If you are a GROUP PRACTICE, please list the names of each professional practicing in your group and his/her Maryland Medicaid provider number and membership effective date. All practitioners in the group MUST be enrolled as a Maryland Medicaid provider.

8) MEDICARE INFORMATION
If you are participating in Medicare, please list the fiscal intermediaries with whom you are enrolled (i.e. Blue Cross of Maryland, Traveler's Group Hospital Insurance, etc) and enter the provider number each has assigned to you.

9) ALTERNATE ADDRESS INFORMATION
Enter the Pay-To-Address address, you want your Medicaid reimbursement checks mailed. If you leave this section blank, your checks will be mailed to the primary practice location entered on the first page of the application.

Enter the Correspondence Address you want all your Medicaid related correspondence and remittance advices mailed. If you leave this area blank, correspondence will be mailed to the primary practice location entered on the first page of the application. Also, please indicate if you would like to receive correspondence electronically. If yes, please include your e-mail address on the first page of the application.

10) OTHER PRACTICE INFORMATION
Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses where you are currently practicing. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

11) AUTHORIZATION
Please sign and date the application.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION INSTRUCTIONS

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at 410-767-5340

.

MEDICAL CARE PROGRAM * PROVIDER APPLICATION

COUNTY CODES

01	Allegany	07	Cecil	13	Howard	19	Somerset	40	Washington, DC
02	Anne Arundel	08	Charles	14	Kent	20	Talbot	99	Other State
03	Baltimore County	09	Dorchester	15	Montgomery	21	Washington		
04	Calvert	10	Frederick	16	Prince George's	22	Wicomico		
05	Caroline	11	Garrett	17	Queen Annes	23	Worchester		
06	Carroll	12	Harford	18	St. Mary's	30	Baltimore City		

SPECIALTY CODES

PHYSICIAN SPECIALTY CODES

026	Allergy & Immunology
045	Anatomic & Clinical Pathology
046	Anatomic Pathology
041	Anesthesiology
031	Cardiovascular Disease
053	Child & Adolescent Psychiatry
047	Clinical Pathology
004	Colon & Rectal Surgery
032	Critical Care Medicine
060	Dermatological Immunology/Diagnostic & Laboratory Immunology
058	Dermatology
059	Dermatopathology
017	Diagnostic Lab Immunology
055	Diagnostic Radiology
043	Emergency Medicine
033	Endocrinology & Metabolism
029	Family Practice
034	Gastroenterology
028	General Practice
003	General Vascular Surgery
008	Gynecologic Oncology
035	Hematology
036	Infectious Disease
030	Internal Medicine
009	Maternal & Fetal Medicine
037	Medical Oncology
025	Neonatal – Perinatal Medicine
038	Nephrology
014	Neurological Surgery
050	Neurology
051	Neurology with Special Qualification in Child Neurology
044	Nuclear Medicine
057	Nuclear Radiology
007	Obstetrics & Gynecology
015	Ophthalmology
013	Orthopedic Surgery
183	Osteopath
012	Otolaryngology
186	Pathology
018	Pediatric Cardiology
019	Pediatric Critical Care Medicine
020	Pediatric Endocrinology
021	Pediatric Gastroenterology
022	Pediatric Hematology - Oncology
023	Pediatric Nephrology
024	Pediatric Pulmonology
002	Pediatric Surgery
016	Pediatrics
048	Physical Medicine & Rehabilitation
011	Plastic Surgery
052	Psychiatry
049	Public Health & General Preventive Medicine
039	Pulmonary Disease
056	Radiation Oncology
054	Radiology
010	Reproductive Endocrinology
040	Rheumatology
001	Surgery
005	Thoracic Surgery
006	Urology

DENTAL SPECIALTY CODES

113	Dental – Other
123	Endodontics
057	Nuclear Radiology
131	General Dentistry
181	Oral Surgery
182	Orthodontics
187	Pedodontics
188	Periodontics

-

PHARMACY SPECIALTY CODES

147	Home IV Therapy
151	Hospital Outpatient Pharmacy
156	Institutional Pharmacy
168	Multi-Specialty Pharmacy
184	Other Pharmacy
202	Retail Chain Pharmacy
204	Retail Single Pharmacy

MEDICAL CARE PROGRAM * PROVIDER APPLICATION

PROVIDER TYPE CODES

AC	Acupuncture	51	EPSDT Therapeutic Intervention	23	Nurse Practitioner (Indiv. Or Group)
50	ADAA Certified Addictions Outpatient Prog.	52	EPSDT Therapeutic Nursery	24	Nurse Psychotherapist (Indiv. Or Group)
T1	Ambulance Services	HH	Halfway House (Substance Abuse)	25	Nursing Agency (Private Duty)
39	Ambulatory Surgical Center	70	HMO	57	Nursing Facility
75	Assisting Living Services Provider	40	Home and Community Based Services, Other	76	Nursing Home Waiver Provider
AT	Attendant Care Waiver	41	Home Health Agency	18	Occupational Therapist (Indiv. or Group)
19	Audiology Services Provider	71	Hospice Provider	63	Oxygen Services
80	Behavior Consultant Provider	01	Hospital, Acute	44	Personal Care Aide
81	Case Management	03	Hospital, Rehabilitation Acute	45	Personal Care Aide Agency
CC	Certified Professional Counselor	04	Hospital, Rehabilitation Chronic	46	Personal Care Aide Level 4 Agency
82	Children's Medical Services (CMS) Provider	05	Hospital, Chronic	47	Personal Care Monitor
13	Chiropractor	06	Hospital, Special Pediatric	RX	Pharmacy
30	Clinic, Abortion	07	Hospital, Special Psychiatric	16	Physical Therapist
31	Clinic, Children and Youth	55	Intermediate Care Facility – Addiction (ICF-A)	20	Physician
32	Clinic, Drug Abuse (Methadone)	56	Intermediate Care Facility for the Mentally Retarded (ICF-MR)	11	Podiatry
33	Clinic, Family Planning	64	Kidney Disease Program	15	Psychologist
34	Clinic, Federally Qualified Health Center	10	Laboratories, Medical	PR	Psychiatric Rehab. Service Facility
35	Clinic, Local Health Department	91	Local Education Agencies/Local Lead Agencies	53	Residential Service Agency/ Home Health Aide Provider
36	Clinic, Maryland Qualified Health Centers	72	MCO	88	Residential Treatment Center
37	Clinic, Rural Health	42	Medical Day Care, Adult	SB	School Based Health Center
38	Clinic, General	43	Medical Day Care, Children	93	Senior Center Plus
90	DDA Services Provider	CM	Mental Health Case Management Provider	SA	Services to Medically Complex Patients in Nursing Facilities
14	Dental	MC	Mental Health Clinic	94	Social Worker
84	Diabetes Education	27	Mental Health Group Provider (Psychotherapist, Social Worker, Nurse Psychotherapist)	17	Speech/Language Pathologist
60	Diagnostic Services, other	29	Mental Hygiene Administration Service	TC	Therapeutic Community
61	Dialysis Facilities	MT	Mobile Treatment	28	Therapy Group Provider (PT.OT. Speech)
85	Dietician/Nutritionists	21	Nurse Anesthetists (Indiv. Or Group)	12	Vision Care
62	DME/DMS	22	Nurse Midwife (Indiv. Or Group)		

TYPE OF PRACTICE CODES

35	Group Practice	99	Other
50	HMO	20	Pharmacy, single store
30	Individual Practice	21	Pharmacy, 2-10 stores
31	Individual Practice, L/P hospital only	22	Pharmacy, 11+ stores
32	Individual Practice, Emerg. Room only	23	Pharmacy, hospital based
33	Individual Practice, O/P or clinic only	24	Pharmacy, nursing home based
10	Nursing Home	25	Pharmacy, tax supported

MEDICAL CARE PROGRAM * PROVIDER APPLICATION

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

1) APPLICATION TYPE:

☐ New Enrollment

☐ Existing Provider/Change Provider Number

I am applying as a…. Please check one:

Requested Enrollment Begin Date

☐ Group

☐ Individual/Practitioner – Solo Practitioner or Member of a Group (*Please circle type)*

☐ Facility/Institution/ Business/Agency (*Please circle type)*

2) PROVIDER INFORMATION

*Please refer to the instructions for the appropriate codes.

Group/Facility/Business/Agency Name			Fiscal Year End Date
Physician/Practitioner Last Name	First Name		Title
Contact Person Name and Telephone Number		E-mail/Website Address	
Primary Practice Address		Suite Number	Handicap Access
City	State		Zip Code
Telephone Number	Fax Number	*County Code	*Provider Type Code
Employer Identification Number	Name of EIN Owner		Social Security Number

3) LICENSE/PERMIT INFORMATION

License/Permit Type	State Issued	License/Permit Number	Issue Date	Expiration Date
Medical				
DEA				
MDLAB				
CLIA				
NABP				
Pharmacy				
Other				

8) MEDICARE INFORMATION

Name	Medicare Number

9) ALTERNATIVE ADDRESS INFORMATION

Pay to Address

Address

City	State	Zip Code

Correspondence Address

Address

City	State	Zip Code

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available? ☐ YES ☐ NO

10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. *Please refer to the instructions for appropriate codes.

Practice Address #2	Suite Number	Handicap Access

City	State	Zip code

Telephone Number	* County Code	License Number_____ Expiration Date_____

Practice Address #2	Suite Number	Handicap Access

City	State	Zip Code

Telephone Number	*County Code	License Number _____ Expiration Date_____

4) PRACTICE INFORMATION

* Please refer to the instructions for appropriate codes.

* Type of Practice	*HMO Type Category
_____ _____	_____ _____

5) SPECIALITY INFORMATION

* Please refer to the instructions for the appropriate codes.

Primary/Secondary Specialty	*Specialty Code	Certification Date	Certification Number

6) SPECIALTY VERIFICATION

Please check the applicable statement and attach the required documentation. Pursuant to amendments to Physicians Services Regulations (COMAR 10.09.02), effective July 1. 1979, the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the following criteria:

☐ I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.

☐ I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.

☐ I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.

☐ I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty that I am board eligible is attached.

☐ I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

If your application is for a group or professional association, each physician in the group or association who wishes to be considered a specialist must submit the required verification.

7) GROUP MEMBERSHIP INFORMATION

Group Name	Provider Number	Begin Date

11) AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

Date_____ _____

Signature of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

_____

Print of Type Name of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

_____

Signature of Owner (in the case of a Pharmacy)

Please return completed application to: Systems and Operations Administration
Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

SECTION D - PROVIDER APPLICATION * PRACTITIONER AND GROUP ADDENDUM

PRACTITIONER

If you are participating in a group practice, do you also provide care to Maryland Medicaid recipients in your private practice and wish to be reimbursed directly by the State? (Your personal tax identification number must appear on this application)

☐ YES ☐ NO

GROUP

If your group is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties:

Name of Facility _____

Address _____

Title _____

Duties _____

Is your group salaried by the above institution? ☐ YES ☐ NO

If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as a pharmacy)? ☐ YES ☐ NO

If you are an O.D., are you practicing optometry exclusively? ☐ YES ☐ NO or optometry as well as preparing and dispensing eyeglasses (as an optician)? ☐ YES ☐ NO

Is your group operating a Local Health Department Clinic? ☐ YES ☐ NO

Is your group operating a Freestanding Clinic ☐ YES ☐ NO

NOTE: All practitioners in a group must be enrolled as Medical Care Program providers.

LABORATORY INFORMATION

Completion of this section is required by individual practitioners and groups. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying codes of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☐ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☐ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☐ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

SECTION D - PROVIDER APPLICATION * INSTITUTION ADDENDUM

Your Fiscal Year End Date:

Bed Data

Service Type	Number of Beds
Intermediate Care (ICF)	
Acute Inpatient (INP)	
Skilled Nursing (SNF)	
Chronic Hospital (CHB)	
Mental Retardation (MR)	
Other (OTH)	

DIALYSIS FACILITIES

Medicare Provide Number _____

Attach a copy of letter with assigned Medicare Provider Number.

Attach a copy of the letter(s) from your intermediary showing all current composite rates.

Note: You will be paid ONLY for the rate(s) appearing in this/these letters(s) in addition to those services provided, but not included in the composite rate.

PORTABLE X-RAY AND OTHER DIAGNOSTIC SERVICES MUST SUPPLY THE FOLLOWING:

Maryland Medical Test Unit Permit No. _____

Do you intend to bill for portability? ☐ YES ☐ NO

Note: All portable x-ray and other diagnostic service providers located within Maryland or serving patients located within Maryland MUST have a Maryland Test Unit Permit. The only out-of-state portable x-ray and other diagnostic services providers that do not have to have a Maryland Medical Test Unit Permit are those that serve Maryland Medicaid recipients in the State in which the provider is located and they must provide a Medicare number.

LABORATORY INFORMATION

Completion of this section is required. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.

Do you provide medical laboratory services for your own patients? ☐ YES ☐ NO

Do you provide medical laboratory services for other than your own patients? ☐ YES ☐ NO

Do you receive specimens that are obtained from other sites located in Maryland? ☐ YES ☐ NO

All Maryland practitioners are required to have a Maryland Laboratory Permit or Letter of Exception Number (§Health General Article 17-202 and 17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.

PLEASE COMPLETE FORM DHMH 4126-G, PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM, AND SUBMIT WITH PROVIDER APPLICATION.

PLEASE COMPLETE FORM DHMH 4126-G, PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM, AND SUBMIT WITH PROVIDER APPLICATION.

SECTION D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

_____

Name of your Medical Service of Supply provider Ownership (as contained on your application

(Applicable to all Providers of items or services[i] except for individual practitioners or groups or practitioners[ii]

Pursuant to 42 CFR "455.100 et. Seq., the disclosure of the following is a required portion of the Maryland Medicaid Provider Application. Therefore, please answer the following questions and sign this document affirming that this information is true and complete, and return with your application. If necessary, please attach continuation sheets.

A. **NAME AND MAILING ADDRESS** of any person who, with respect to the Title XVIII and/orTitle XIX Provider[iii]:

1. is an officer or director

   _____

   _____

2. is a partner

   _____

   _____

3. has a direct or indirect ownership interest[iv] of 5% or more

   _____

   _____

4. has a combination of direct and indirect ownership interests equal to 5% or more in the Provider

   _____

   _____

5. is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider

   _____

   _____

   _____

B. With respect to any subcontractor in which the title XIX Provider has, directly of indirectly, an ownership or control interest of 5% or more, name any person who falls within A. 1-5 above, as applied to the subcontractor and specify which of the above categories he falls within

   _____

   _____.

C. 1. If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship.

   _____

   _____

   _____

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling.

   _____

   _____

SECTION D

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE FORM

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services or the Maryland Department of Health and mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

A. the ownership of any subcontractor with which the title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and

B. any significant business transactions[v], occurring during the 5-year period ending on the date of such request, between the Provider and any wholly-owned supplier[vi] or any subcontractor.

C. the identity of any management company that will operate or contract with the applicant to operate the facility.

D. the ownership of equipment utilized for direct patient care.

_____ _____

AUTHORIZED SIGNATURE

_____

POSITION

---

[i] "Provider" or "provider" of services means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

[ii] "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

[iii] Identify any persons named, who are related to others named, as spouse, parent, child or sibling.

[iv] a. "Ownership Interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

b. "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

c. "Determination of ownership or control percentage"

1) Indirect ownership interest – The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in the corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, multiply the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

[v] " Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expense of a provider.

[vi] "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of a hospital bed, or a pharmaceutical firm).

SECTION E – STATE AFFIDAVIT

Whoever knowing and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable State laws. In addition, knowing and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity is already license, a revocation of that license.

I certify that the administrative and procedural requirements contained in COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrative and resident care policies, By-laws and other organizational documentation, written agreements with outside resources/consultants, committee meetings, staff qualifications and written development program such as inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the Office of Health Care Quality, in writing, before the effective date of the change. I further certify that I will notify the Office of Health Care Quality if there are any future "substantive changes in facility management and operation, " as defined in the instructions for completion of the Federal affidavit, that significantly affect policies and procedures and that notice will be given in writing before the effective date of the change.

NAME OF FACILITY:

_____

_____

Signature of Authorized Official **Title** **Date**

SECTION F –WORKERS' COMPENSATION LAW QUESTIONAIRE

Name of Facility

_____

(Please type or print)

Address of Facility

_____

(Please type or print)

Do you have Workers' Compensation Insurance for your employees?
(Check One) □ **YES** □ **NO**

If you have answered **YES** above; please provide the following information:

Policy Number: _____

Binder Number: _____

Insurance Company: _____

Effective Date: _____

Expiration Date: _____

If you have answered **NO,** please attach a copy of your Certificate of Compliance in accordance with State Workers' Compensation Laws.
(See attached form A52 and Instruction Sheet)

Please note
Your license cannot be issued unless this form is completed, signed, dated and provided to this Administration along with your "Certificate of Compliance" if applicable.

_____ _____

Signature Date

SECTION G – CERTIFICATE OF COMPLIANCE APPLICATION

INSTRUCTION SHEET

Please REVIEW INSTRUCTIONS BEFORE COMPLETING the Certificate of Compliance Application

The Workers' Compensation Commission will accept only the original application. (Do Not fax, photocopy or electronically reproduce) Type or print LEGIBLY or application may be returned without review. Complete the application in its entirety.

Line #1 Name of Company (If the company does not have a name leave blank)

Line # 2 Owner's Name (If corporation, list the name of the contact person)

Line # 3 Complete Business Address (P.O. Box is not acceptable)

Line # 4 Complete Mailing Address

Line # 5 Phone Number (Pager Number is not acceptable)
FEIN or Social Security Number is required. (If partnership, please Initial & list the last four digits of SS# for each partner. If using a FEIN#, SS #'s are not necessary.)

Line # 6 Check appropriate box (see back of application). Additionally, where indicated, please complete and attach Exclusion Form C-16R.

Line # 7 Sign and Date (If partnership, All partners must sign)

NOTE: Maryland Law § 9-201 requires an employer with one or more employees to carry workers' compensation insurance. Any employer with workers' compensation insurance is to submit proof (policy or binder number) of coverage to the Agency where they are applying for their license. DO NOT COMPLETE THE CERTIFICATE OF COMPLIANCE APPLICATION IF YOU HAVE INSURANCE COVERAGE. If you have any questions regarding the Certificate of Compliance, please call 410-864-5297 or 1-800-492-0479 and ask to be transferred to extension 5297. If you do not follow the aforementioned instructions, it may cause a delay in the processing of your application. Thank you for your cooperation.

CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

(1) a certificate of compliance with this title; or
(2) the number of a workers' compensation insurance policy or binder.

If a business is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance shall be submitted to the Workers' Compensation Commission pursuant to Labor & Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry workers' compensation insurance coverage and to enable that business to apply for and obtain a license or permit from a government agency that requires proof of workers' compensation insurance coverage. A Certificate of Compliance is **not** workers' compensation insurance and is not binding on the Workers' Compensation Commission under any circumstance.

NOTE: Maryland Annotated Code LE §9-201 requires a business with one or more employees to carry workers' compensation insurance.

Eligibility: A business may secure a Certificate of Compliance in the name of the business, only if:

(a) the business is a sole proprietor with no employees;

(b) the business is a partnership with no employees other than the individual partners;

(c-f) the business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than corporate officers or limited liability company members who have elected, under §9-206, to be excluded from workers' compensation coverage;

(g) the business is an employer of only "casual employees" as provided under LE §9-205 and defined in Maryland Law; or

(h) the business is an owner operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers' Compensation Commission
Attention: Certificate of Compliance Officer
10 East Baltimore Street • Baltimore, Maryland 21202-1641

Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.

SECTION G – CERTIFICATE OF COMPLIANCE APPLICATION

Licensing Agency's Stamp

APPLICATION FOR CERTIFICATE OF COMPLIANCE

(Please type or print legibly□Review instructions on reverse side prior to completing application)

1. _____
Name of Business (If trading as self, leave blank)

2. _____
Name of Owner(s) If a partnership, print each partner's name (attach separate sheet if necessary)

3. _____ _____ _____ _____
Business Address (P. O. Box Not Acceptable) City State Zip Code

4. _____ _____ _____ _____
Mailing Address City State Zip Code

5. (_____)_____ _____
Phone Number (Pager Number Not Acceptable) FEIN or Social Security Number(s)

6. The above named business would qualify for a Certificate of Compliance for the following reason: **(Check the appropriate box and do not modify or qualify the stated reasons in any way.)**

a. ☐ Sole Proprietor: The business is a sole proprietorship with no employees.
b. ☐ Partnership:The business is a partnership with no employees other than the individual partners.
c. ☐ A Maryland Close Corporation (attach Exclusion Form C-16R): The business is a Maryland Close Corporation with no employees other than corporate officers.
d. ☐ Farm Corporation (attach Exclusion Form C-16R): The business is a farm corporation with no employees other than corporate officers.
e. ☐ Professional Corporation (attach Exclusion Form C-16R): The business is a professional corporation with no employees other than corporate officers.
f. ☐ Limited Liability (attach Exclusion Form C-16R): The business is a limited liability company with no employees other than limited liability company members.
g. ☐ Casual Employees: The business only employs casual workers as provided in LE §9-205 and defined under Maryland Laws.
h. ☐ Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Tractor) vehicle and meets the requirements of exclusion as defined under LE §9-218.

I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

7. _____ _____
Signature(s) **If a partnership, all partners must sign** (Use separate sheet if necessary) Date

After careful review of this application and based solely on the information contained in or attached to this application, the application is ☐ **APPROVED** ☐ **DISAPPROVED.**

_____ _____
Authorized Signature Date

An applicant who receives notice of disapproval may: (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with §§ 10-222 and 10-223 of the State Government Article.

Form A52 (Rev. 12/01/00)

WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-1641
TEL: (410) 864-5100 OR (1-800) 492-0479
TTY USERS CALL VIA MARYLAND RELAY

Date Stamp – WCC Use Only

EXCLUSION FORM

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.**

DATE: _____ DATE COMPANY NOTIFIED INSURANCE COMPANY: _____

NAME OF CORPORATION'S INSURANCE COMPANY: _____

NAME OF COMPANY: _____

TYPE OF COMPANY: (Circle One) Farm Corporation, Close Corporation, Professional Corporation, Limited Liability Company

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Typewritten Name and Title of Officer or Member Electing Exclusion	% of Ownership	Personal Signature

IMPORTANT: Submit original form to the Workers' Compensation Commission, a copy to the insurer of the corporation, and keep a copy for your files.

FORM C-16R (Rev. 12/01/00)

BEGINNING Pro Forma Balance Sheet

Facility Name: _____

Date: _____

ASSETS		LIABILITIES	
CURRENT ASSETS:		CURRENT LIABILITIES	
CASH	_____	ACCOUNTS PAYABLE	_____
ACCOUNTS RECEIVABLE	_____	CURRENT PORTION – LTD	_____
INVENTORY	_____	NOTE PAYABLE	_____
INTERCOMPANY	_____	OTHER LIABILITIES	_____
TOTAL CURRENT ASSESTS	_____	TOTAL CURRENT LIABIITIES	_____
FIXED ASSETS:		LONG-TERM LIABILITIES	
LAND	_____	LONG TERM DEBT	_____
LAND IMPROVEMENTS	_____		_____
BLDG & IMPROVEMENTS	_____		_____
FURNITURE & EQUIP	_____		_____
			_____
LESS ACCUM DEP	_____		_____
NET FIXED ASSETS	_____	TOTAL LONG-TERM LIABIITIES	_____
OTHER ASSETS:		PAID IN CAPITAL	_____
FINANCING COSTS	_____		_____
START UP COSTS	_____		
	_____		
TOTAL OTHER ASSETS:	_____	TOTAL EQUITY	_____
TOTAL ASSETS	**_____**	**TOTAL**	**_____**

SECTION H Proof of Financial Ability to Operate Schedule **Nursing Home Licensure**
ENDING Pro Forma Balance Sheet

Facility Name: _____

Date: _____

ASSETS		LIABILITIES	
CURRENT ASSETS:		CURRENT LIABILITIES	
CASH	_____	ACCOUNTS PAYABLE	_____
ACCOUNTS RECEIVABLE	_____	CURRENT PORTION – LTD	_____
INVENTORY	_____	NOTE PAYABLE	_____
INTERCOMPANY	_____	OTHER LIABILITIES	_____
TOTAL CURRENT ASSESTS	_____	TOTAL CURRENT LIABIITIES	
FIXED ASSETS:		LONG-TERM LIABILITIES	
LAND	_____	LONG TERM DEBT	_____
LAND IMPROVEMENTS	_____		_____
BLDG & IMPROVEMENTS	_____		_____
FURNITURE & EQUIP	_____		_____
			_____
LESS ACCUM DEP	_____		_____
NET FIXED ASSETS	_____	TOTAL LONG-TERM LIABIITIES	_____
OTHER ASSETS:		PAID IN CAPITAL	_____
FINANCING COSTS	_____		_____
START UP COSTS	_____		
	_____		
TOTAL OTHER ASSETS:	_____	TOTAL EQUITY	_____
TOTAL ASSETS	_____	**TOTAL**	_____

SECTION H Proof of Financial Ability to Operate Schedule **Nursing Home Licensure**

PROJECTED STATEMENT OF REVENUES AND EXPENSES PERIOD: FROM _____ TO _____

FACILITY NAME _____

		1ST MONTH	2ND MONTH	3RD MONTH	4TH MONTH	5TH MONTH	6TH MONTH	7TH MONTH	8TH MONTH	9TH MONTH	10TH MONTH	11TH MONTH	12TH MONTH	TOTAL
OCCUPANCY PERCENTAGE														
PATIENT DAYS														
REVENUES:	PRIVATE													
	MEDICAID													
	MEDICARE													
	ANCILLARY													
	OTHER/HMO/INS													
	OTHER													
GROSS REVENUES														
CONTRACTUAL ADJUSTMENTS														
NET REVENUES														
EXPENSES														
	ADMINISTRATIVE													
	PROPERTY													
	PLANT OPERATION													
	DIETARY SERVICE													
	LAUNDRY & LINEN													
	HOUSEKEEPING													
	NURSING													
TOTAL EXPENSES														
N.H. INCOME (LOSS)														

SECTION H Proof of Financial Ability to Operate Schedule **Nursing Home Licensure**

PROJECTED STATEMENT OF REVENUES AND EXPENSES PERIOD: FROM _____ TO _____

FACILITY NAME _____

	1 ST MONTH	2ND MONTH	3RD MONTH	4TH MONTH	5TH MONTH	6TH MONTH	7TH MONTH	8TH MONTH	9TH MONTH	10TH MONTH	11TH MONTH	12TH MONTH	TOTAL
ADMINISTRATIVE													
SALARY-ADMIN													
SALARY-OTHER													
SALARY-OTHER													
MGMT FEES													
OTHER ADMIN													
BENEFITS													
TOTAL ADMINISTRATIVE													
PROPERTY													
DEPRECIATION													
AMORTIZATION													
INTEREST													
RENT													
TAXES													
INSURANCE													
TOTAL PROPERTY													
PLANT OPERATION													
SALARIES													
UTILITIES													
OTHER PLANT OP													
TOTAL PLANT OPERATIONS													
DIETARY SERVICES													
SALARIES													
RAW FOOD													
OTHER													
TOTAL DIETARY													
LAUNDRY & LINEN													
SALARIES													
OTHER													
TOTAL LAUNDRY & LINEN													
HOUSEKEEPING													
SALARIES													
OTHER													
TOTAL HOUSEKEEPING													
NURSING													
SALARIES													
OTHER													
ACTIVITIES & SS													
OTHER PAT CARE													
TOTAL NURSING COSTS													
TOTAL COSTS													

SECTION H Proof of Financial Ability to Operate Schedule **Nursing Home Licensure**

STATEMENT OF CASH FLOWS

FACILITY NAME: _____

PERIOD FROM _____ TO _____

	1ST MONTH	2ND MONTH	3RD MONTH	4TH MONTH	5TH MONTH	6TH MONTH	7TH MONTH	8TH MONTH	9TH MONTH	10TH MONTH	11TH MONTH	12TH MONTH	TOTAL
FUNDS AVAILABLE													
CASH BEGINNING													
NET INC FROM OPER													
SUBTOTAL													
ADD													
DEPRE/AMORT													
DECREASE IN INV													
INCREASE IN A/P													
INCREASE IN ACC LIAB													
TOTAL ADDITIONS													
TOTAL FUNDS AVAILABLE													
DEDUCT													
DEBT SERVICE													
INCREASE IN A/R													
INCREASE IN INV													
TOTAL USAGE													
CASH AVAIL AT END OF MONTH													

SECTION I: ADVERSE ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

ADVERSE ACTIONS THAT MUST BE REPORTED

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

   Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal of State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connections with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal of State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under Federal of State law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any misdemeanor conviction, under Federal of State law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation of suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION I: ADVERSE ACTIONS/CONVICTIONS (continued)

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever has an adverse action listed on page 1 of Section I imposed against it?

   ☐ YES – Continue Below ☐ NO

2. If yes, report each adverse action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.
   Attach a copy of the adverse action documentation and resolution.

Adverse Action	Date	Taken By	Resolution

SECTION J: CHAIN HOME OFFICE INFORMATION

This section captures information regarding chain organizations. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicaid fee-for-service contractor.

For more information on chain organizations, se 42 C.F.R. 421.404.

CHECK HERE ☐ IF SECTION J DOES NOT APPLY AND SKIP THIS SECTION

A. TYPE OF ACTION THIS PROVIDER IS REPORTING

Check one:	Effective Date	**Sections to Complete**
☐ Provider in chain is enrolling in Medicare for the first time (*Initial Enrollment of Change of Ownership*)	_____	Complete all of Section J.
☐ Provider is no longer associated with the chain organization previously reported	_____	Complete section J-C, identifying the former chain home office.
☐ Provider has changed form one chain to another	_____	Complete Section J in full to identify the new chain home office.
☐ The name of provider's chain home office is changing *(all other information remains the same).*	_____	Complete Section J-C.

B. CHAIN HOME OFFICE ADMINISTRATOR INFORMATION

Name of Home Office First Name	Middle Name	Last Name	Jr., Sr., etc.

Title of Home Office Administrator	Social Security Number	Date of Birth (*mm/dd/yyyy)*

C. CHAIN HOME OFFICE INFORMATION

1. Name of Home Office as Reported to the Internal Revenue Service

2. Home Office Business Street Address Line 1 (*Street Name and Number)*

Home Office Business Street Address Line 2 (*Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number (*if applicable)*	E-mail Address (*if applicable)*

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date (*mm/dd)*
4. Home Office Fee-For-Service Contractor	Home Office Chain Number

D. TYPE OF BUSINESS STRUCTURE OF THE CHAIN HOME OFFICE

Check one:

Voluntary:

- ☐ Non-Profit – Religious Organization
- ☐ Non-Profit – other *(Specify)*_____
- ☐ Proprietary
- ☐ Individual
- ☐ Corporation
- ☐ Partnership_____
- ☐ Other *(Specify)*_____

Government:

- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other *(Specify)*_____

E. PROVIDER'S AFFILIATION TO THE CHAIN HOME OFFICE

Check one:

- ☐ Joint Venture/Relationship
- ☐ Managed/Related
- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other *(Specify):*_____

K

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 ĐF23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 ÐF31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A- Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delega ted tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocati onal nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-relat ed services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technician s - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certifi cation and specialized training to assist a licensed/certi fied/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certifi cation and specialized training to assist a licensed/certi fied/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medic aid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

	Tag Number	A Services Provided 1	2	3	B Full-Time Staff (hours)	C Part-Time Staff (hours)	D Contract (hours)
Administration	F33						
Physician Services	F34						
Medical Director	F35						
Other Physician	F36						
Physician Extender	F37						
Nursing Services	F38						
RN Director of Nurses	F39						
Nurses with Admin. Duties	F40						
Registered Nurses	F41						
Licensed Practical/ Licensed Vocational Nurses	F42						
Certified Nurse Aides	F43						
Nurse Aides in Training	F44						
Medication Aides/Technicians	F45						
Pharmacists	F46						
Dietary Services	F47						
Dietitian	F48						
Food Service Workers	F49						
Therapeutic Services	F50						
Occupational Therapists	F51						
Occupational Therapy Assistants	F52						
Occupational Therapy Aides	F53						
Physical Therapists	F54						
Physical Therapists Assistants	F55						
Physical Therapy Aides	F56						
Speech/Language Pathologist	F57						
Therapeutic Recreation Specialist	F58						
Qualified Activities Professional	F59						
Other Activities Staff	F60						
Qualified Social Workers	F61						
Other Social Services	F62						
Dentists	F63						
Podiatrists	F64						
Mental Health Services	F65						
Vocational Services	F66						
Clinical Laboratory Services	F67						
Diagnostic X-ray Services	F68						
Administration & Storage of Blood	F69						
Housekeeping Services	F70						
Other	F71						

Name of Person Completing Form	Time
Signature	Date

Form CMS-671 (12/02)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

Civil Rights Information Request For Medicare Certification

Form Approved: OMB No. 0990-0243

Expiration Date: 10/31/2010

Instructions: Complete all fields and return this form, with the required documents, to your State Health Department, along with your other Medicare Application Materials.

I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address: _____
Street Number and Name

_____ - _____
City or Town *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: ( ) - _____ TDD: ( ) - _____

FAX: ( ) - _____ E-mail: _____

Type of Facility: _____ Number of employees: _____

Corporate Affiliation: _____ Reason for Application: Circle One
Initial Medicare Certification or Change of Ownership

II. Documents Required for Submission
(Additional guidance is available at: (www.hhs.gov/ocr/crclearance.html)

1.	Two signed and completed originals of the form HHS-690, Assurance of Compliance.
2.	Your Nondiscriminatio n Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see example).
3.	Description of methods used to disseminate your nondiscri mination policies/notices (e.g., describe where you post your Nondiscriminatio n Policy, and include brochures, postings, ads, etc.).
4.	Facility admissions policy that describes eligibility requirements for your services.
5.	Copies of brochures, pamphlets, etc. with general information about your services.
6.	Procedures to effectively communicate with persons who are limited English proficient (LEP), including (see example): a) Process for how you identify individuals who need language assistance; b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interp reter(s) and/or interpreter service(s); c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served; d) Appropriate restrictions on the use of family and friends as LEP interpreters; e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondi scrimination notices, etc.
7.	Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manu al or speaking skills, including (see example): a) Process to identify individuals who need sign language interpreters or other assistive services; b) Procedures to provide interpret ers and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpret er(s) and/or interpreter service(s); c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System; d) A list of available auxiliary aids and services; e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served; f) Appropriate restrictions on the use of family and friends as sign language interpreters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

Civil Rights Information Request For Medicare Certification

Form Approved: OMB No. 0990-0243

Expiration Date: 10/31/2010

8.	Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see example).
9.	For healthcare providers with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
10.	For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances (see example).
11.	A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted.

III. Certification

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

Name and Title of Authorized Official	Signature	Date

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF
1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts
or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

SECTION N
DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act,
as Amended and Title 42 Code of Federal Regulations (CFR)
Chapter IV, Part 489)

AGREEMENT
between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

_____

doing business as (D/B/A)_____

In order to receive payment under title XVIII of the Social Security Act, _____
_____
D/B/A_____as the provider of services, agrees to conform to the provisions of section 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U,S,C, section 1001)

Name_____ Title_____

Date_____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:	
NAME (*signature)*	
TITLE	DATE
ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:	
NAME (*signature)*	
TITLE	DATE
ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:	
NAME (*signature)*	
TITLE	DATE